

# Walter Reed Cardiovascular Center



## A Monthly Newsletter of the Cardiology Division of Walter Reed Army Medical Center

### Commentary

Marina Vernalis, DO FACC

The initiation of our Outreach Clinic for new patient consults at Fairfax has been successful. Eddie Atwood, Anwar Malik and Don Anderson have each spent a Wednesday during October seeing consults. They will continue to evaluate new referrals every other Wednesday.

We recognize that appropriate and timely feedback on direct order tests like ECHOs and Holters is problematic. While the mechanism for forwarding results undergoes improvement (i.e. immediate population of results into ICDB), please contact our Nurse Manager or any physician staff for assistance.

Of note, Eddie Atwood had another publication (electronic version) in the NEJM Images In Clinical Medicine entitled "T-U-P Syndrome, or Pseudo-atrial flutter" – [www.nejm.org](http://www.nejm.org)

Finally, we remain available for e-mail, phone or page consultations. Utilize the provided contact information for patient diagnostic or treatment questions.

### Cardiovascular Update

Daniel Simpson, MD FACC

"Clinical Safety of MRI Early After Coronary Artery Stent Placement"\*

**Background:** Manufacturers of coronary stents and professional associations recommend waiting 4-8 weeks after stent placement before performing any elective MRI. It has been felt that MRI may be unsafe before endothelialization due to device dislodgement, heating or generation of electrical currents. In vitro and animal studies demonstrate no or minimal ferromagnetism & migration with the currently available stents. There is limited clinical outcomes data for early MRI after coronary stenting.

**Methods:** Review of the Mayo Clinic Percutaneous Coronary Intervention Database for patients receiving a stent (and treated with aspirin + a thienopyridine) followed by an MRI within 8 weeks. Occurrence of death, MI and repeat revascularization within 30 days of MRI were determined.

**Results:** MRI was performed within 18 days of stenting (median – 0 to 54 days). There were no subacute stent thrombosis, no MIs, 3 repeat revascularizations and no cardiovascular deaths. The event rates were similar to stent patients not undergoing MRI.

**Conclusion:** MRI within 8 weeks of coronary artery stenting appears to be safe, so postponing the examination does not seem to be needed.

\*J Am Coll Cardiol 2003;42:1295-8

### Guideline Review

Daniel E. Simpson, MD FACC

We often receive consults for advice regarding appropriate risk factor modification. There is good evidence in support of traditional risk factor treatment for the reduction of cardiovascular events. However, many patients take numerous supplements while failing to reduce traditional risk factors. There is little data to support the use of "supplements".

"Coronary Disease Risk Factors and Evidence That Treatment Can Reduce the Risk for Coronary Disease Events: Recommendations for Treatment of Risk Factors"\*

### Class I

- Treatment of hypertension according to JNC guidelines
- Smoking cessation therapy
- Management of diabetes
- Comprehensive cardiac rehab program
- Lipid lowering therapy in patients with documented or suspected CAD and LDL  $\geq$  130, with a target LDL < 100
- Weight reduction in obese patients in the presence of HTN, HLP, or DM

### Class IIa

- In patients with documented or suspected CAD and LDL 100-129, several options are available: lifestyle/drug therapy to target LDL < 100, weight reduction/increase activity in persons with the metabolic syndrome, and/or consider treatment of elevated triglycerides or low HDL
- Therapy to lower non-HDL in patients with documented or suspected CAD and triglycerides > 200, with a target non-HDL <

- Weight reduction in obese patients in the absence of HTN, HLP, or DM

Class IIb

- Folate therapy in patients with elevated homocysteine
- Identification and appropriate treatment of clinical depression
- Intervention directed at psychosocial stress reduction

Class III

- Initiation of hormone replacement therapy in post-menopausal women for the purpose of reducing cardiovascular risk
- Vitamin C and E supplementation
- Chelation therapy
- Garlic
- Acupuncture
- Coenzyme Q

Class I – General agreement that procedure/treatment is useful & effective

Class II – Conflicting evidence and/or divergence of opinion

Class III – Not useful/effective and in some cases may be harmful

\*ACC/AHA Practice Guidelines for Patients with Chronic Stable Angina (2002)

[www.acc.org/clinical/statements.htm](http://www.acc.org/clinical/statements.htm)

**Cardiovascular Trials at WRAMC**

CARDIASTAR

PFO closure device versus standard anti-coagulation therapy with coumadin in patients with an embolic TIA/CVA and no other etiology

Questions/Referrals: Please contact Daniel Simpson

OPTIMIZE-HF

Assessment of inpatients with CHF and/or LV dysfunction to determine if guideline treatment is appropriately implemented

Questions/Referrals: Please contact Stephen Welka

WARCEF

Randomized, double-blind comparison of coumadin versus aspirin for the reduction of death and stroke in heart failure patients (EF < 30% and in sinus rhythm)

Questions/Referrals: Please contact Stephen Welka